JONI ERNST
IOWA

WASHINGTON, DC OFFICE
825 B/C HART SENATE OFFICE BUILDING
WASHINGTON, DC 20510
PHONE: 202–224–3254
FAX: 202–224–9369

United States Senate

February 23, 2015

COMMITTEES
ARMED SERVICES
AGRICULTURE, NUTRITION AND FORESTRY
HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS
SMALL BUSINESS AND ENTREPRENEURSHIP

Richard J. Griffin
Acting Inspector General
U.S. Department of Veterans Affairs
Office of Inspector General (50)
801 Vermont Avenue, NW
Washington, D.C. 20420

Dear Mr. Griffin:

The Department of Veterans Affairs (VA) has emphasized its commitment to providing high-quality, safe and effective health care for our nation's veterans. With more than 1,700 medical facilities located across the country, the VA health care system is the largest medical education and health professions training program in the United States. It employs approximately 250,000 doctors, nurses, and support staff who are responsible for treating and rehabilitating the millions of veterans who return home after enduring significant sacrifices in serving our country. In light of recent events however, I am concerned that veterans are not receiving the highest quality of mental health care and management at VA Central Iowa Health Care System.

On February 20, 2015, Army and Iraq War veteran, Richard Miles, was found deceased at Water Works Park in Des Moines, Iowa. I am deeply troubled by a report by *WHO TV*, which claims Richard may have not have received adequate mental health care from the Department of Veterans Affairs.[1] According to the news story, Richard may have sought long-term care at the VA on multiple occasions, but instead received medication and was sent home.[2]

While the law enforcement investigation into Richard's death is on-going, it is tragic our nation lost a veteran who may not have received the mental health treatment he deserved. According to VA estimates, there are approximately 22 veteran suicides per day. Earlier this month, VA Secretary Bob McDonald said, "Of those roughly 22 veterans…17 of them, we estimate, are not connected to the VA. And what we need to do is get those 17 connected because we know how to treat this.[3]" The VA cannot excuse lapses in care, management and compassion, when our veterans reach out to the VA and fail to receive the life-saving treatment they need and deserve.

As a member of the Senate, I have a responsibility to ensure our nation lives up to the promises it has made to its veterans. Furthermore, as someone who deployed in support of the Iraq War, it is my top priority to ensure our veterans receive the care they deserve after selflessly sacrificing for

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[1] Jodi Whitworth, "Friends Question if Veteran's Death Could Have Been Prevented," WHOtv.com, February 21, 2015; http://whotv.com/2015/02/21/friends-question-if-veterans-death-could-have-been-prevented/
[2] Jodi Whitworth, "Friends Question if Veteran's Death Could Have Been Prevented," WHOtv.com, February 21, 2015; http://whotv.com/2015/02/21/friends-question-if-veterans-death-could-have-been-prevented/
[3] NPR, "Obama Signs Act Designated to Prevent Suicide Among Veterans," February 12, 2015; http://www.npr.org/2015/02/12/385793944/obama-signs-act-designed-to-prevent-suicide-among-veterans

our nation. I request your office conduct an immediate and thorough investigation into the VA Central Iowa Health Care System mental health care programs, treatment provided to veteran Richard Miles, and Mr. Miles' requests for mental health care and the subsequent treatment received.

Thank you for your attention to this important matter. A written response is requested by no later than February 27, 2015. If you have any questions concerning this request, please contact my staff via Jabari White at (202) 224-3254.

Sincerely,

Joni K. Ernst

Joni Ernst
United States Senator